Comments From:
Marty Lynch| Executive Director
LifeLong Administrative Offices

1) Goals: I think the goals look very good …very clear, concise and I think what we are trying to accomplish. Couple of comments on other issues below.

2) Financing: models are ok…in either model I believe it should be clear that savings would be shared with all players: state, plan or organizing entity in managed fee for service, and providers. We want to align incentives and make sure that all have incentives to participate….and avoid perception that state will take Medicare savings to deal with its own budget crisis in an unfair way….that won't work.

3) Site selection process: I am concerned about taking a significant number of entities through a complex selection process. I assume it will be costly and time consuming for groups to put together a response. I would rather see an initial response with questions you think are key to answer….to give state an idea of range of interest. I would then push the state to narrow down substantially to the types of entities/numbers/approaches that they might realistically be interested in to participate in the pilot. That number could certainly be more than the four pilots called for but not a large number and then ask that subset for much more detailed and lengthy process of information and negotiation with the state to choose the final four. I would let respondents know at each step of the way where they stand. (e.g. we don't think you would be competitive for the pilot but we hope to expand in x years….at that point we encourage you to be ready to re-apply.) (or…you are one of the final 8, we can only choose 4, here are factors we are considering).

4) Potential Demonstration Participants:

a. I am more interested in seeing a carved in approach rather than carved out. For example specific plans to include DD and how to do it, or IHSS recipient duals and how to do it, or mental health patients and how to do it. I do think it is ok to pick sub-populations of duals…e.g. elderly and concentrate on success with that population…but I would see it as targeting and piloting with a rational group as first step to get to broader dual populations and sub-groups which will require different approach.
b. I also think it is ok to target a regional area vs. county wide if again there is an integration rationale that makes more sense for a sub-area as a first step in moving towards a whole county.
c. It is important to think through whether we want a range of counties with different levels of infrastructure and different probabilities for success. Politically I lean toward representation of a range of types of structures (COHS, 2-plan, rural managed FFS) but all with highly competent organizations that are likely to succeed. The pilots probably can't afford a disaster in terms of maintaining consumer and political support.
d. I am probably ok with passive enrollment assuming good consumer protections but also assuming that the plan where duals are being enrolled passively has an active PACE option and includes any willing FQHC provider (or traditional safety net providers for duals) who meets integration criteria. We can't allow a situation, which is present in some counties for the 1115 Waiver Low Income Health Plan where some counties/plans have chosen to exclude key community health center providers and keep all of the dollars in-house. That would be disastrous for both community infrastructure and for continuity of care….and would sink the pilots in the long run.

Good job overall. Again happy to discuss further.

Marty